

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

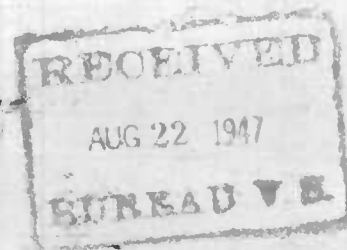
2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 193

<b>1. PLACE OF DEATH:</b> County..... Howard City or town..... Woodbine (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... all life Hospital, institution, or street address where death occurred: How long in hospital or institution?..... no				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... Maryland County..... Howard City or town..... Woodbine (If outside city or town limits, write RURAL and give nearest town) Street No..... Old Armajoles Road (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> Charles Raymond Dorsey				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> 43		<b>5. Color or race</b> Colored		<b>6. (a) Single, married, widowed, or divorced</b> Married			
<b>6. (b) Name of husband or wife</b> Irma Dorsey				<b>6. (c) If alive, give age</b> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> April 21, 1904				<b>8. AGE:</b> Years 43 Months 3 Days 16 If less than one day hrs. min.			
<b>9. Birthplace</b> Frederick Co Md (Town, county, and state)				<b>10. Usual occupation</b> Laborer			
<b>11. Industry or business</b> Farm				<b>12. Name</b> John W Dorsey			
<b>13. Birthplace</b> Howard Co				<b>14. Maiden name</b> Nellie Broomes			
<b>15. Birthplace</b> Howard Co				<b>16. Informant</b> J W Dorsey			
<b>Address</b> Woodbine Md				<b>17. Burial</b> Paid thereon Aug 9 1947 (Burial, cremation, or removal, which?) month (day) (year)			
<b>Cemetery or crematory</b> Poplar Spring				<b>Location</b> Poplar Spring			
<b>18. Funeral director</b> H. M. Snyder				<b>Address</b> Mt. Airy			
<b>19. 8-9/-</b> 1947				<b>Registrar</b> E. Paul Morris			

<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> August 6 1947 at 2 P. M	
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> August 6 1947 to August 6 1947 and that I last saw him alive on at no time	
<b>Immediate cause of death</b> Epilepsy	<b>DURATION</b> 10 yrs
<b>Due to</b>	
<b>Due to</b>	
<b>Other conditions</b>	
(Include pregnancy within 3 months of death)	
<b>Major findings of operations</b>	
Date of op.	
<b>Autopsy results</b>	
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>	
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>	
Accident, suicide, or homicide Date of	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of Injury	Injured at work?
<b>23. SIGNATURE</b> Alpha N Herbert Md	
<b>DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY</b> M. D. or other	
Address: Ellicott City Md Date signed 8-6-47	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

07118

195

## 1. PLACE OF DEATH:

County HowardCity or town Near Laurel  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

Gorman Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Near Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. Gorman Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Verrick Orville French

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Gray Fabian French6. (c) If alive, give age 37 years7. Birth date of deceased (mo., day, yr.) March 26, 19008. AGE: Years 47 Months 4 Days 11 If less than one day

hrs. min.

9. Birthplace Pittsboro, Iowa  
(Town, county, and state)10. Usual occupation General manager11. Industry or business High Ice Cream Co.12. Name Engel Cole French13. Birthplace Pittsboro, Iowa, Penn.14. Maiden name Jennie M. Rimpston15. Birthplace N. Y.16. Informant Jessie E. DavisAddress Muscatoine, Iowa17. Burial Date thereof Aug 8, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory East Lincoln CemeteryLocation Bladenburg Rd. Md.18. Funeral director Dr. W. H. DonaldsonAddress Laurel, Maryland19. Aug 7, 1947 Frank Shipley  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947 at 3:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1947 to August 5 1947and that I last saw him alive on August 5 1947Immediate cause of death Laceration of stomach & intestineswith lacerations to lungs & kidneysDURATION 9 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Lacerations of stomach & intestinesto & lacerations to lungs & kidneys Date of op. Dec 23, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Donaldson M.D.Address Laurel Md. Date signed 8/7/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 12 194  
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PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 164c

67119

195

1. PLACE OF DEATH: Howard  
 County.....  
 City or town.....North Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Howard  
 City or town.....North Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Patterson Rd.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

3. (a) FULL NAME  
Thomas Oscar Hawkins

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Pearl Bennett  
 6. (c) If alive, give age deceased years  
 7. Birth date of deceased (mo., day, yr.) Dec 27, 1910

8. AGE: Years 36 Months 8 Days 16 If less than one day hrs. min.

9. Birthplace.....Wheaton Montgomery Co, Md.  
 (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business Farm

12. Name.....Oscar Hawkins

13. Birthplace.....Clarksburg Md.

14. Maiden name.....Maudie Jones

15. Birthplace.....Wheaton Md.

16. Informant.....Maudie C. Hawkins

Address.....Savage, Md.

17. Burial Date thereof Aug 16, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Clarksburg

Location.....Clarksburg, Montgomery Co. Md.

18. Funeral director.....Dr. W. H. H. H. H. H.

Address.....Laurel, Maryland

19. 8/15/47 19. Shunkshipley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....August 13 19. 47 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 19. 47 to August 13 19. 47  
 and that I last saw him alive on at no time 19. 47

Immediate cause of death.....Burnshot wound of

Brain DURATION Inst

Due to.....Rifle Bullet

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tick in the following: 8-13-47  
Suicide Date of 8-13-47

Accident, suicide, or homicide.....

Where did injury occur? North Savage Howard Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Burnshot wound Injured at work? no

Alpha N. Herbert M.D.

23. SIGNATURE.....Alpha N. Herbert M.D.  
 DEPT. MEDICAL EXAMINER OF HOWARD COUNTY M. D. of the

Address.....Ellicott City Md. Date signed.....8-13-47

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AUG 18 1947  
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 West Main Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Blanche Victoria Kerger

## 3. (b) Social Security Number

None4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 10, 1882

6.(c) If alive, give age..... years

8. AGE:

65328

It less than one day

..... hrs.

..... min.

9. Birthplace

Baltimore Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

J. W. Van Hoosen

13. Birthplace

New Amsterdam, N. Y.

MOTHER

14. Maiden name

Irak Krager

15. Birthplace

Baltimore Maryland

16. Informant

Address

William F. Kerger Jr.  
Ellicott City Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

8/19/47  
(month) (day) (year)

Cemetery or crematory

St. Augustine Cemetery

Location

Elbridge Maryland

18. Funeral director

Address

Eastern Sons  
Ellicott City Maryland

19.

(Date rec'd by registrar)

Aug 8, 1947John D. Loughman  
Regist.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1947 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1, 1947 to August 7, 1947and that I last saw her alive on August 7, 1947

Immediate cause of death

DURATION

Cerebral Hemorrhage4 days

Due to

Hypertensive Cardiovascular disease1 yr

Due to

Diabetes Mellitus3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John D. Loughman  
M. D. or other

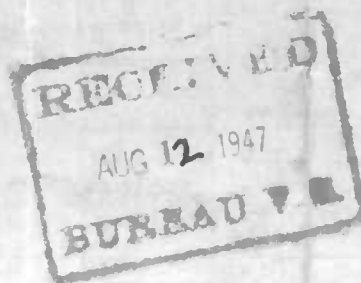
Address

Ellicott City Md.

Date signed

8/17/47







67121

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County... Howard

City or town... Elliott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Franklyn Kirkwood Jr

## 3. (b) Social Security Number

214-14-5984

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Laura A Kirkwood

7. Birth date of

deceased (mo., day, yr.)

Jan 11 - 1911

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

36

7

hrs.

min.

9. Birthplace

Elliott City, Howard County, Md.

(Town, county, and state)

10. Usual occupation

Postal Clerk

11. Industry or business

MOTHER FATHER

12. Name

William F. Kirkwood Sr

13. Birthplace

Elliott City, Md.

14. Maiden name

Lida S. Smith

15. Birthplace

Elliott City, Md.

16. Informant

Laura A. Kirkwood

Address

Falshe Elliott City, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Aug 14 - 1947

Cemetery or crematory

St. Johns

Location

Elliott City, Md.

18. Funeral director

F.C. Robinson

Address

Elliott City

19.

(Date rec'd by registrar)

Aug 12, 1947

Date

John B. Longman

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard

City or town... Elliott City

(If outside city or town limits, write RURAL and give nearest town)

Street No... Fals Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 11, 1947, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 11, 1947, to August 11, 1947

and that I last saw him alive on August 11, 1947

Immediate cause of death

Teratoma of testis with metastasis

DURATION

6 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Longman M.D. or other

Address... Elliott City, Md. Date signed... 8/11/47

MARGIN RESERVED FOR BINDING

VS A45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 14 1947  
BUREAU 7 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07122

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County Howard  
City or town Ellicott City Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Howard  
City or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elsie May Kuhn

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife John C. Kuhn7. Birth date of deceased (mo., day, yr.) Jan 23 1897 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 50 Months 7 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balto (Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Repp13. Birthplace Balto14. Maiden name Ida Powers15. Birthplace Balto16. Informant John C. KuhnAddress Old Ford Rd Ellicott City17. Burial Date thereof Aug 23 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good ShepherdLocation Howard County18. Funeral director J.C. HiginbothamAddress Ellicott City19. Aug 22 1947 John B. Longman  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947 at 10 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to August 1947 and that I last saw him alive on August 21 1947Immediate cause of death Coronary occlusionDue to Essential hypertensionDue to Nephrectomy

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John B. Longman M. D. or otherAddress Ellicott City Md Date signed Sept 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 25 1947

BUREAU

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

07123

## CERTIFICATE OF DEATH

Reg. Dist. No.

195

## 1. PLACE OF DEATH:

County Howard  
High Ridge, Laurel, Md.  
 City or town Laurel  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HowardCity or town High Ridge near Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charlotte (Lottie) Miles

## 3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Richard T. Miles

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1872

8. AGE: Years 75 Months 4 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Laurel Md.  
(Town, county, and state)10. Usual occupation House wife11. Industry or business Home12. Name Theodore Morrison13. Birthplace ?14. Maiden name Margaret ?15. Birthplace ?16. Informant Charles R. MilesAddress Laurel, Md.17. Burial Burial Date thereof Aug. 7, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation Laurel, Md.18. Funeral director DeWitt DonaldsonAddress Laurel, Md.

19. 7/6/47 19. Mark Shipley  
(Date rec'd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1947 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1947 to Aug. 4, 1947 and that I last saw him on Aug. 3, 1947.

Immediate cause of death

Hypernephroma (left) 6 mos.Due to ✓Due to ✓Other conditions ✓

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Mark Shipley, M.D.Address Savage, Md. Date signed 7/6/47

RECEIVED  
AUG 9 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

## 1. PLACE OF DEATH:

County HowardCity or town Savage  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 63 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Savage  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lorenzo Earl Pickett

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WidowedB. (b) Name of husband or wife Sara Belle Pickett

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 9, 18708. AGE: Years 26 Months 10 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Carroll Co. Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Cotton mill

FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

MOTHER

14. Maiden name Kizora Jane Hull15. Birthplace Carroll Co. Md.16. Informant Lola Pickett ReaneyAddress Savage, Md.17. Burial Date thereof Aug 30, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Savage CemLocation Savage Md18. Funeral director W. W. WitherspoonAddress Savage Md19. 8/28/47 Frank Shipley  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27<sup>th</sup> 1947 at 8 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1<sup>st</sup> 1947 to Aug. 27<sup>th</sup> 1947 and that I last saw him alive on Aug. 27<sup>th</sup> 1947

Immediate cause of death

Cerebral Haemorrhage

DURATION

3 days

Due to

Hypertension3 yrs.

Due to

arterio-sclerosis3 yrs.Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. \_\_\_\_\_

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

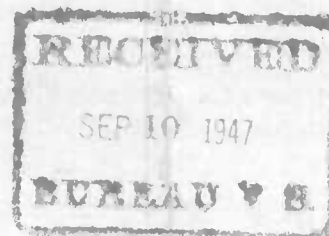
Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Frank Shipley MD  
Savage, Md. 8/28/47  
Address \_\_\_\_\_ Date signed \_\_\_\_\_





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

071259

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County HOWARDCity or town WOODSTOCK  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HOWARDCity or town WOODSTOCK COLLEGE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Edmund E. Ponholzer

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 26 1879

8. AGE:

Years

Months

Days

If less than one day

68213

hrs.

min.

9. Birthplace

3011, Bavaria

(Town, county, and state)

10. Usual occupation

Religious brother

11. Industry or business

FATHER

12. Name

NOT KNOWN

13. Birthplace

""

MOTHER

14. Maiden name

""

15. Birthplace

""

16. Informant

WOODSTOCK COLLEGE RECORD

Address

WOODSTOCK MD

17.

BURIAL

Date thereof

8-11-47

(Burial, cremation, or removal. Which?)

Cemetery or crematory

WOODSTOCK COLLEGE CEM.

Location

WOODSTOCK MD

18. Funeral director

Bernard C. Hasle

Address

121 E West St.

19.

8/9/47

(Date rec'd by registrar)

J. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 8 19 47 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1943 to Aug 1947and that I last saw him alive on Aug 8 19 47

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold H. Burns M.D.

M. D. or other

Address

519 N. Charles St.Date signed Aug 5, 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

67126

195

## 1. PLACE OF DEATH:

County Howard  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard  
 City or town Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 57 Washington St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Felma Mildred Shillingburg

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Archie Estlin Fyfe Shillingburg  
 6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1888

8. AGE: Years 58 Months 8 Days 6 If less than one day  
 hrs. min.

9. Birthplace Leakysburg, Maryland  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name James Thomas Fyfe

13. Birthplace Leakysburg, Md.

14. Maiden name Concepcion James Fyfe

15. Birthplace Leakysburg, Md.

16. Informant Dr. Fyfe, Jr.

Address Savage, Md. (Fyfe)

17. Buried Date thereof Aug. 13, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Savage

Location Savage, Md.

18. Funeral director Mr. White & Sons

Address Leakysburg, Md.

19. 8/13/47 19 Shillingburg  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 47 at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 19 46 to Aug 11 19 47  
 and that I last saw him alive on Aug 11 19 47

Immediate cause of death Cancer of liver DURATION 5 mo

Due to Cancer of sigmoid 8 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

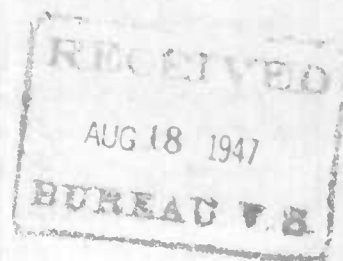
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. McCreary, Jr. M. D. or other

Address 402 Main St Laurel, Md. Date signed 8/11/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07127

Reg. Dist. No.

195

## 1. PLACE OF DEATH:

County Hancock  
 City or town New Laurel  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
All Saints Rd.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Hancock  
 City or town New Laurel  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. All Saints Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Annie Sullie  
 4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Thomas H. Sullie7. Birth date of deceased (mo., day, yr.) Sept 30, 1870

8. AGE: Years 76 Months 10 Days 7 If less than one day  
 hrs. min.

9. Birthplace Wardman, Isle of Man  
(Town, county, and state)10. Usual occupation Laundress11. Industry or business Home12. Name Henry Callan13. Birthplace Sahagun, Isle of Man14. Maiden name Unknown15. Birthplace Unknown16. Informant Thomas H. SullieAddress Laurel, Md.17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Aug 11, 1947  
(month) (day) (year)Cemetery or crematory NiagaraLocation Niagara Falls N. Y.18. Funeral director McWitt & SonsAddress Laurel, Maryland19. Aug 7 47 Frank Shipley  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 19 47, at 11:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 20 19 46, to Aug 7 19 47and that I last saw him alive on August 7 19 47Immediate cause of death Acute MyocarditisDue to Chronic MyocarditisDue to Chronic HypertensionOther conditions Coronary atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. M. McWittAddress Laurel, Md.Date signed 8/7/47

